FTF Internal Audit Service

Internal Control Evaluation 2021/22

Report No. T08/22

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Audit Follow-Up Co-ordinator

Audit and Risk Committee
External Audit

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Draft Report Issued	24 December 2021
Management Responses Received	3 March 2022
Target Audit & Risk Committee Date	20 January 2022
Final Report Issued	**3 March 2022**

EXECUTIVE SUMMARY

1. As Accountable Officers, Chief Executives are responsible for maintaining a sound system of internal control to manage and control all the available resources used in the organisation. This review aims to provide early warning of any significant issues that may affect the Governance Statement.

OBJECTIVE

2. The principal objective of this review is to provide assurance to the Chief Executive, as Accountable Officer, that there is a sound system of internal control that supports the achievement of the Board's objectives.

3. This year's Internal Control Evaluation (ICE) was designed to coordinate with future internal audit work on progress with Strategic and Workforce Planning, with initial work focussing on the adequacy of the arrangements in place to develop the Strategy and the Workforce Plan. The second phases of both reviews will consider the effectiveness of these arrangements.

4. This ICE also provides a detailed assessment of action taken to address previous internal audit recommendations from the 2020/21 ICE and Annual Report, and assess the adequacy and effectiveness of internal controls, giving time for remedial actions to be taken before year-end, thereby allowing the year-end process to be focused on year-end assurances and confirmation that the required actions have been implemented.

5. This evaluation assessed the design and operation of the controls in place and specifically considered whether:

   - Governance arrangements are sufficient, either in design or in execution, to control and direct the organisation to ensure delivery of sound strategic objectives.

6. Whilst there was no overarching corporate/strategic risk relevant to this review, our audit specifically considered whether governance arrangements are sufficient, either in design or in execution, to control and direct the organisation to ensure delivery of sound strategic objectives.

AUDIT OPINION

7. Ongoing and required developments and recommended actions are included at Section 2.

8. The Annual Internal Audit Report, issued on 27 July 2021, was informed by detailed review of formal evidence sources including Board, Standing Committee and Executive Leadership Team (ELT). As well as identifying key themes, the Annual Internal Audit Report made recommendations on:

   - Strategy
   - Integration
   - Waiting Times risk
   - Workforce Planning
   - Performance Reporting
   - Information Governance risk

9. The action relating to Workforce Planning is on track and while the Strategy and Integration recommendations are due for completion by March 2022, a clear focus on progressing these is required as there has been slippage in expected progress to date. The Waiting Times risk review has not been progressed and there has been some minor slippage on the other two recommendations.

10. Six of seven recommendations from the 2020/21 ICE are still in progress and there has been significant slippage on the Strategy recommendation. Completed actions from previous ICE and Annual Report recommendations are included under each strand of governance and ongoing recommendations from the 2020/21 ICE are detailed in table 1.

11. NHS Tayside has successfully managed the shorter term operational risks, ensuring continuation of service delivery and good performance throughout the pandemic. The focus must now be on management of longer term risks, most importantly the Waiting Times risk, and development of overall Clinical Strategy. Completion of the 2020/21 ICE and Annual Report recommendations will be crucial to the organisation's long terms success.

12. In this report, we have provided an update on progress to date and, where appropriate, built on and consolidated previous recommendations to allow refreshed action and completion dates to be agreed. This has culminated in 11 recommendations for which management have agreed actions to progress by year end. Whilst this appears to be a large number of recommendations given the overall positive conclusions within the report, these recommendations are primarily suggestions to enhance governance improvement activities already underway within NHS Tayside.

13. We recommend that this report is presented to each Standing Committee so that key themes can be discussed and progress against the recommendations can be monitored.

KEY THEMES

14. 2021/22 has continued to be very challenging and NHS Tayside has performed exceptionally well in these circumstances, with operational performance exceeding the Scottish average in a number of areas. Focus on strategy development has not matched the expectations at year-end. The Board will need to understand how best to balance the mitigation of short-term operational risks against the actions required to mitigate the longer-term strategic risks which could cause significant difficulties for the Board in the coming years.

15. Our 2020/21 Annual Report noted that a number of the issues highlighted within that year's ICE were being addressed as part of a wide range of governance and strategic initiatives. We were pleased to see steady progress in:

- Endorsement of assurance principles and adoption of revised Standing Committee Governance and Assurance Guidance;
- Continuing development of Risk Management arrangements, although further work is required to fully incorporate the impact of Covid;
- Continued enhancement of the quality of assurance reports to the Care Governance Committee;
- Refresh of the Collective Leadership and Cultural Strategic Framework 2018- 2023 to support implementation in year 3;
- Enhancements in performance reporting;
- Ongoing development of the 3 year Workforce Plan;
- Completion of the Digital Strategy consultation process;
- Production of the Cyber Incident Response Plan and Cyber Alert Response Plan.

KEY DEVELOPMENTS SINCE THE ISSUE OF THE ANNUAL REPORT

16. Key developments since the issue of the Annual Internal Audit Report included:

- Approval of version 4 of the Remobilisation Plan and introduction of the quarterly Action Tracker to monitor progress;
- An Active Governance workshop in October 2021;

- The Strategic Risk Management Board Development Event in September 2021;
- Development of the risk appetite statement, shared with the Strategic Risk Management Group on 15 December for approval;
- The Public Health Committee held a Public Health Strategy Development event covering the purpose of the Strategy, priority areas, stakeholder engagement and how to measure impact;
- Establishment of the Operational Unit Clinical Governance Committee, Clinical Policy Governance Group and Safety Oversight Group;
- Archiving of the Clinical Governance strategic risk as the target risk score was achieved;
- Development of the new Mental Health and Learning Disability Services strategic risk;
- Ongoing implementation of the new Public Protection Framework for NHS Tayside.
- Overall, there has been steady progress on recommendations from the ICE and the Annual Report for 2020/21. Where action is still to be concluded, the Board has been informed of the planned approach and timescales, as well as associated improvement plans.

ACTION

17. The action plan has been agreed with management to address the identified weaknesses. A follow-up of implementation of the agreed actions will be undertaken in accordance with the audit reporting protocol.

ACKNOWLEDGEMENT

18. We would like to thank all members of staff for the help and co-operation received during the course of the audit.

A Gaskin, Bsc. ACA
Chief Internal Auditor

TABLE 1 Update of Progress Against Ongoing Actions since Annual Report		
Agreed Management Actions with Dates	**Management Actions Updates with Dates**	**Assurance Against Progress**
Internal Control Evaluation Report 2020/21 – T06/22		
1. Sustainability & Transformation		
• Develop remobilisation plans into annual service plans, incorporating budgets and workforce planning discussions. • Introduce greater formality around the remobilisation process. • Completion of a comprehensive evaluation exercise of the service changes made. • Completion of remobilisation plan template by all clinical groups and specialties, including unplanned care. • Develop monitoring of adverse events due to Covid19. ***Action Owner: Chief Executive & Director of Finance*** ***Date of expected completion for all of the above is the 31 March 2022.***	RMPv3 and RMPv4 submitted to Scottish Government and a final version of the RMP4 provided to Board on 16 December 2021 for assurance and will be shared on the NHS Tayside website. Remobilisation Action Tracker introduced and regularly monitored. The Director of Performance & Activity is a member of the national Short Life Working Group SLWG which is contributing to guidance around the next stages. The strategic plan will be template based and narrative light. Progress on monitoring adverse events due to Covid to be confirmed.	 On track for completion
2. Strategy & Transformation		
• Identification of a Director level sponsor and project lead for strategic planning and change. • Plan and timetable for how the new strategy and supporting strategies will emerge, including governance arrangements and key responsibilities for individuals and groups. • A stock take of previous	Director with specific responsibility for strategic planning not recruited, but the Director of Finance and Chief Executive are actively working on a proposal to recruit and realign existing resource to create dedicated capacity for strategic planning. No reporting on progress through governance structures.	 Significant slippage

transformative projects • Articulation of a clear link between strategy and ongoing service developments. • Overt linkage to realistic medicine, transformative programs, efficiency savings and other initiatives. • Assessment of the risks to achievement. • Board should be provided regular overviews of whether Recovery, Remobilisation and strategy development is on track, key achievements, challenges and risks and any significant implications for strategy and priorities. ***Action Owner: Chief Executive & Director of Finance*** ***Date of expected completion for all of the above was 30 June 2021.***	The Scottish Government Budget for 2022/23 is set out as a transitional budget, paving the way for a full resource spending review in May 2022. This will inform Board direction.	
3. Corporate Governance – Covid19		
• Clearly articulate the impact of Covid19 on the risk profile of the organisation at both the strategic and service level. • Identify all relevant controls mitigating the strategic and service level impacts of Covid19 and implement clear assurance lines. • Risks documented within the Covid19 risk register should be reviewed and escalated if necessary. ***Action Owner: Director of Finance & Head of Strategic Risk and Resilience Planning/Interim Head of Clinical Governance and Risk***	Updated Strategic Risk Profile presented to Board in June and October 2021. Service level risks are updated and reviewed locally. Several Covid19 service risks are recorded in Datix. Strategic impact of Covid19 apparent for some but not all strategic risks. Head of Strategic Risk and Resilience Planning continues to meet with each risk owner to update strategic risks for Covid19 aspects.	 In progress

Management. ***Date of expected completion for all of the above was 30 April 2021.***		
4. Corporate Governance – Standing Committees		
All Standing Committee Lead Officers should provide assurance to the Accountable Officer that they and their standing committees will be in a position to provide the necessary assurance at year end. ***Action Owner: Board Secretary*** ***Date of expected completion for all of the above was 17 August 2021.***	Complete – as per Governance paper to Audit & Risk Committee in (A&RC) November 2021	 Complete
5. Corporate Governance – Performance Reporting		
Covid19 risks need to be fully articulated, measures chosen for reporting should focus on key risks and objectives and provide overt conclusions on those objectives and risk in line with the assurance principles. ***Action Owner: Director of Performance and Systems Management, Business Unit Service Manager*** ***Date of expected completion: Framework development and consultation commenced (July 2021). Formal approval and implementation of Performance Management Framework (December 2021).***	Performance reporting focus has shifted towards understanding the impact of the pandemic on performance against national measures, as well as the incorporation and development of measures aligned with the RMPv4. Action Tracker now includes key measures on: Public Health; Mental Health; Digital Infrastructure and Innovation; Workforce; Supporting Staff Wellbeing; Communications and Engagement. While the performance report does not overtly link to corporate objectives, the Risk Assessment/Management Performance reporting section of the December 2021 board cover paper referred to the strategic risks for Waiting times and RTT targets, Capacity and Flow and Child and Adolescent Mental Health Service. Action point 2 in this report recommends that monitoring	Performance reporting:  Complete Covid risks:  In progress

	and performance reports are overtly related to specific risks and contain an overt conclusion on whether controls are operating as intended, to mitigate the risk effectively.	
6. Clinical Governance – Care Governance		
• Implement a plan for review of the Clinical Governance Strategy, revising timelines and an assessment of the impact of Covid19. • Indentify any new or significant amendments to clinical governance risks. • Consider the impact of Covid19 on the scope/quality of information and its ability to provide appropriate year-end assurances. • Fully articulate changes to controls resulting from Covid19 and any diminution in assurance provided. ***Action Owner: Medical Director, Director of Nursing & Midwifery, Director of Public Health.*** ***Date of expected completion for all of the above is the 30 September 2021.***	Progress delayed due to Covid-19 and further postponed because of ongoing developments. Revised target date for completion. Clinical governance risks continue to be reported to Care Governance Committee; although risks associated with increased waiting times are not yet reported. Impact of Covid-19 requires to be quantified across all assurance papers.	 In progress
7. Succession Planning		
Remuneration Committee should perform succession planning for key strategic posts with NHS Tayside. ***Action Owner:*** **Director of**	Verbal update on the Talent Management Framework and Succession Matrix to October 2021 Remuneration Committee, highlighting the criticality of developing leaders to the required level of	 In progress

Workforce ***Date of expected completion for the above is October 2021***	competency and capacity. Implementation of the Strategy has been delayed due to Covid. Date of expected completion deferred to February 2022.	
Annual Report 2020/21 – T08/22		
1. Strategy		
Introduction of a strategic risk relating to the development and implementation of overall strategy • Appropriate officers identified to own and manage the risk • Effective governance and oversight so that the Board can formally scrutinise the arrangements and be engaged in all key decisions, and in setting the vision/ direction for the next iteration of the plan. ***Director of Finance*** ***March 2022***	A strategic risk to be developed following horizon scanning exercise and consultation with IJB colleagues. Regular updates to be provided to Board and will present a more detailed process to the Board at the appropriate time, which will be before year-end. See comments above on the ICE 2020/21, point 2 - Strategy & Transformation.	 Significant slippage
2. Integration		
NHS Tayside active engagement with the actions agreed as part of the MSG self evaluation and revision of Integration Schemes. ***Director of Finance*** ***March 2022***	No reporting on MSG actions to Tayside NHS Board. Integration Schemes review in progress with target date for completion of March 2022.	 In progress
3. Waiting Times risk		
Review of Waiting Times risk to reflect potential for patients to suffer serious harm if services are not prioritised effectively Re-allocation of risk to the Care Governance Committee Post-Covid the current risk will be updated following an impact	Agreed risk would be updated post-Covid-19 and reported to CGC. Whilst the risk and the associated controls have not yet been presented to the Care Governance Committee, the Medical Director provided a list of the controls which are	 Significant slippage Superseded by new, enhanced recommendation

assessment of the pandemic which will in turn inform future treatment profiles and inform service prioritisation. This post-Covid risk update with any additional controls will be reported to the CGC. ***Medical Director*** ***December 2021***	currently being applied, and we were informed that, due to the ongoing impact of Omicron the view is that the impact assessment would best be carried out in March / April 2022. Internal Audit have provided examples of good practice from other Boards.	
4. Workforce Planning Governance arrangements		
• Agreement of a project plan and timetable to progress Workforce Planning, to support delivery of the Clinical Strategy and links to revised service models. • Effective SGC governance, oversight and scrutiny. ***Director of Workforce*** ***March 2022***	Interim Workforce Plan endorsed by Staff Governance Committee in June 2021, following approval by the APF. Staff Governance Committee demonstrates increased emphasis on workforce planning with risks and controls reviewed and reports detailing work being undertaken on the 3 year Workforce Plan. No Workforce Optimisation risk assurance report between August 2021 and February 2022 (December 2021 meeting cancelled). Workforce Planning templates complete for all but one service areas and key themes extracted. Scottish Government guidance is awaited on format of future Workforce Plans or how they will monitor implementation. However, their primary purpose is for the Board not the Scottish Government and therefore we would expect to see monitoring of the workforce plan objectives through a SMART action plan and appropriate KPIs.	 On track for completion

5. Performance reporting		
Reporting of new measures as a result of Covid-19 to be included in the Staff Governance Quarterly Report with a particular focus on health and wellbeing, safety and mandatory and statutory training. ***Director of Workforce*** ***To be confirmed following confirmation of national direction (August 2021)***	The only associated information that the SGC has received this year related to uptake of the Health & Safety system 'Smartsheet', which includes some Covid related data, an update on the Wellbeing Group, including minutes, and reports on Statutory and Mandatory training which were presented to the June and October 2021 SGC. No overt, data based assurance in relation to staff safety and wellbeing during the Covid19 pandemic was presented to SGC. Departmental remobilisation plans were discussed at Local Partnership Fora, and reported to the Area Partnership Forum, but not the SGC.	 Significant slippage **The inherent risks in this area are still high and reflect that Covid and sickness absences are having a considerable impact.**
6. Information Governance Risk Reporting		
Reconfiguration of the Datix system to send IG alerts to the Information Governance and Cyber Assurance Team when an IG risk has been identified and monitor all operational / service level risks that have an information governance and / or cyber assurance element, with related reporting to the IGCAC Review of the Digital Directorate local risk register to identify any information governance and cyber assurance related risks and those will then be captured in Datix by the Digital Directorate. This will ensure that these information governance and cyber assurance related risks can also be monitored by the Information Governance and Cyber Assurance Team and where appropriate, reported to	The Digital Directorate Risk register is regularly updated, and risks are reviewed each month at the Infrastructure and Operations Group, as well as being a standing item on the Senior Management meeting agenda. Any risks arising or being actively managed which concern both IG and Digital will be added to Datix as appropriate. The Datix system has been now been configured to send alerts to the Information Governance and Cyber Assurance Team when an Information Governance risk has been identified in Datix. IG related risks have been identified with the first report to IGCAC in January 2022. 31 January 2022	 Minor slippage

the IG&CA Committee. **31 October 2021** **Action Owner -** Head of Information Governance and Cyber Assurance, Head of Operations, Digital Directorate.		

CORPORATE GOVERNANCE

Strategic Risks

- 807: Statutory obligations in relation to environmental management

Strategy

The strategic landscape is extremely complex with the SGHSCD delaying requirements for submission to them of a range of strategic documents and national guidance unclear in a number of key areas over which NHS Tayside has sought guidance, not least future funding. We also note that the NHS Recovery Plan contains a number of targets which appear to be extremely ambitious, at best in the current circumstances. Similarly, although much good work has been undertaken within the production of RMP 4, this can only ever be a bottom-up approach, it cannot inform the necessary process of prioritisation or address the need for consideration of issues such as health equity, new demand and prevention which may have a more fundamental impact on how services are delivered, if at all.

Understandably, much of the focus since our annual report has been on dealing with the ongoing impact of the pandemic, which continues to take priority, given its seriousness and urgency. We note elsewhere in this report, the excellent performance of NHS Tayside in this regard, which does demonstrate the ability of NHS Tayside and its Executive Team to deliver rapid change and improvement when required.

However, NHS Tayside will need to balance the very serious risks posed by the current circumstances, with the potentially existential risks to future operations created by the demographic and workforce pressures which were already threatening sustainability across much of NHS Scotland, even before Covid both exacerbated those pressures and created a range of new difficulties. It is important that the Board understands these risks and that Board members are sighted on how NHS Tayside will balance and resolve them.

As it stands, Tayside NHS Board members have not been provided with any formal update on production of the overall Clinical Strategy, although it was informed at a November BDE of how the remobilisation plans will to contribute to future strategic direction.

Whilst as noted above, there are a number of factors that will delay the delivery of a coherent, over-arching strategy and the enabling strategies which support it, not least the need for clear and robust guidance and information from the SGHSCD, there are a number of steps which could be taken now to ensure that the Board is as well prepared as possible to deliver a strategy as and when such direction becomes available. These would include processes to understand changes to population health demand, consideration of how areas such as inequalities and realistic medicine will feed into the process and robust information on finance, workforce and Digital capacity to understand the parameters within which the Board will need to work.

It is also important the Board identifies those areas at greatest risk and in particular those 'critical path' areas where the service may become unsustainable and in a timescale not significantly greater than that required to effect the necessary change.

Given the complexity of the circumstances and the changes to the intended dates for commencement of the process for producing a strategy, Board members should be briefed on the national context, the challenges associated with the 4th wave and an overview of when and how the process will be taken forward, noting that the priority is not necessarily a glossy brochure, but an agreed set of objectives, priorities and changes.

We would also highlight the importance of producing the Public Health Strategy, which is a necessary precursor to development of overall Clinical Strategy and will need to be aligned to the overall direction of travel, including interaction with IJB strategic planning.

Operational Planning & Remobilisation Plan version 4 (RMPv4)

Following approval of Remobilisation Plan version 3 (MPv3) on 27 May 2021, the internal audit ICE 2020/21 report recommended establishing greater formality of reporting of remobilisation progress through governance structures. A detailed Action Tracker was agreed by the ELT to provide assurance on progress and to identify emerging risks. The first report was presented to the December 2021 Board meeting, following initial consideration by the Performance and Resources Committee (P&RC) in August 2021. This is an excellent document and the risks highlighted within it should be reviewed to ensure they are fully reflected in the organisation's strategic risk profile.

RMP4 was presented to the Board Development Event (BDE) in September 2021 before submission to Scottish Government at end September 2021. It provided an update on the delivery of key priorities described in RMPv3, alongside a short narrative on areas where there had been significant change or development since RMPv3, and what these mean for the Board. The final RMPv4 was presented to Board on 16 December 2021.

Tayside NHS Board approved Winter Planning arrangements on 16 December 2021. The Winter Plan describes the resilience and response NHS Tayside and its partner organisations will have in place to cope with expected winter pressures, within the Covid19 landscape.

Covid19

There were no changes in governance arrangements for Board and Standing Committees until December 2021, when the Staff Governance Committee (SGC) and Remuneration Committee meetings in December 2021 were stood down due to the rise of Omicron, and unavailability of both the Chair and Vice Chair of the Remuneration Committee.

Covid19 updates were reported to each Board meeting and provided information on the vaccination programme, contact tracing, the work of the Specialist Health Protection function, public communications and advice, workforce support and updates on Gold Command and the multi-partner Incident Management Team. Most recently, the December report detailed new mitigations in response to the Omicron variant.

Resilience

Internal audit T15/21 – Resilience Planning, provided an opinion of *Reasonable Assurance* on arrangements for Major Incident Planning and provided an opinion of *Limited Assurance* on Business Continuity Planning. Recommendations were agreed to review the resilience planning service level risk and provide more robust resilience planning assurances to the SRMG and P&RC. In addition, reporting of completion of Business Continuity Plans will now be strengthened and processes for central review and testing of Business Continuity Plans will be more closely monitored by the Strategic Risk & Resilience Planning Team, **w**ith non-compliance followed up and escalated and reported as necessary.

Governance

There has been a range of positive governance developments and ongoing work, including:

- Endorsement of assurance principles;
- Adoption of revised Standing Committee Governance and Assurance Guidance;
- Continued use of the NHS Scotland 'Model Meeting Paper Template Completion Guidance';
- The Active Governance workshop in October 2021;
- Progress with assurance mapping ;

- Planned work on Best Value.

Governance Blueprint

The Corporate Governance Action Plan was generated from the Board self-assessment undertaken in 2019. This area was last reviewed in internal audit T11/20 – Governance Blueprint, issued 20 November 2019. At that time, six of 16 actions were in progress and, as last reported via the 30 April 2021 Board Action Points update, the NHS Scotland Corporate Governance Steering Group advised that the next self assessment survey should take place in 2021. However, this will not take place until the revised national Governance Blueprint is issued.

This would be an opportune time to provide assurance on progress with outstanding actions from the original Governance Blueprint, including revision of the Public Health Strategy, review of resources to implement and support the Engagement & Communications Plan and development of a programme to improve the visibility of the Board and the Board Members engagement with front line staff. The impact of Covid-19 on the implementation of these actions should be quantified and steps taken to progress key actions, prioritising as necessary and noting any overlap with other initiatives, such as the remobilisation plan.

Assurance Mapping & Best Value

Internal Audit continues to facilitate the work of the Assurance Mapping group and to liaise with the Board Secretary to consider how the agreed principles can be adapted to the specific needs of NHS Tayside. In addition, we are assisting Board Officers in their continuing review and update of the Mental Health Strategic risk and looking at how assurance mapping can be used to enhance the robustness of assurances provided by Directors in accordance with the Scottish Public Finance Manual, as well as ensuring that all work is congruent with national governance initiatives.

The organisation's approach to Best Value is being reviewed through the Finance function, with progress reported through the Governance Review Group. Best practice examples from other Health Boards have been obtained, and advice sought from both external and internal auditors. A proposal to address each Best Value characteristic on a cyclical basis will be progressed in early 2022 and internal audit has offered to provide comment as well as looking at the possibility of incorporating Best Value characteristics into the assurance mapping framework.

Culture

The person-centredness model in Tayside was approved by the Care Governance Committee in October 2020 and aligns with the refreshed Collective Leadership and Cultural Strategic Framework and Talent Framework accepted by the Staff Governance Committee in June 2021.

A Whole System Person Centredness Leadership Group provides support to improve care experience for staff, patients, families and carers; transform person-centred leadership and care cultures; ensure community engagement, including public and patient involvement and shared decision making.

Integration

The Tayside NHS Board Action Points update at 24 June 2021 stated that progress with MSG actions will be reported on a six monthly basis to the NHS Board. However, no updates have been provided since December 2019.

A Short Life Working Group first met on 22 July 2021 to revise the Integration Schemes and development sessions have been held with elected members, IJB members and NHS Tayside Board. The group has engaged with relevant officers for each section of the Integration Scheme and a draft was made available to Chief Executives week beginning 20 December 2021. The timescale for formal consultation will be agreed, with the aim of having all three schemes signed off in March 2022.

Audit Follow Up

The audit follow up system is maintained by internal audit and reported through the A&RC. At 31 October 2021, 9 internal audit actions remain outstanding, all had extended dates (3 risks assessed as red, 3 amber and 3 green).

Performance

The Scottish Government Annual Review was on 15 November 2021 and the Chief Executive gave a verbal update to the 6 December 2021 Board.

The focus of performance reporting has shifted towards understanding the impact of the pandemic on performance against national measures, as well as the incorporation and development of measures aligned with the NHS Tayside RMPv4. It is planned that reporting will continue to evolve to align with the key objectives outlined in RMPv4. The performance report does not overtly link to corporate objectives but does cross-refer to the strategic risks for Waiting times and RTT targets, Capacity and Flow and Child and Adolescent Mental Health Service.

The Performance Action Tracker has been enhanced to include key measures on: Public Health; Mental Health; Digital Infrastructure and Innovation; Workforce; Supporting Staff Wellbeing; Communications and Engagement.

Performance reports do not currently provide overt conclusions on their impact on specific risks and whether controls are operating as intended. The overall reporting framework at governance level should triangulate resources, performance and risk within the overall governance framework. Best practice would be for monitoring and performance reports to be overtly related to specific risks and to contain an overt conclusion on whether controls are operating as intended, to mitigate the risk effectively.

In the face of the pandemic, NHS Tayside has demonstrated impressive operational delivery, enabling the organisation to continue to deliver strong performance compared to NHS Scotland as a whole as evidenced to the 16 December 202 Board meeting:

- NHS Tayside has continued to successfully deliver the national standard for 31 day cancer waiting times. 62 day performance remained below the target of 95% at 90.6% in October 2021.
- Routine elective activity is progressing as per the agreed phased remobilisation planning, and elective Inpatient / Daycase procedure (TTG) activity over April-October 2021 remained above planned levels with 9,351 patients treated against a plan of 8,263 patients.
- Outpatient delivery over April-October 2021 remained above planned levels with 56,654 patients seen against a plan of 44,698 patients.
- Patients waiting beyond 6 weeks for a key diagnostic test rose to 5,534 at end August 2021, and reduced to 5,095 at end of October as Endoscopy activity outstripped demand.
- CAMHS 18 week referral to treatment performance has improved to above target at 90.4% in October 2021.
- Psychological Therapies 18 week referral to treatment performance has improved to above target at 93.6% in October 2021.
- Unscheduled care (A&E waits) performance remains the highest performance in mainland Boards in Scotland and increased to 91.7% in October 2021.
- NHS Tayside continues to achieve 100% for IVF waiting times.

The December 2021 performance report did however report that while clinics continue to remobilise and a Waiting List validation exercise is being progressed, the volume of new outpatients waiting

beyond 12 weeks has increased over the last 4 months period. Delayed Discharges continued to rise from June 2021.

There is a detailed RMPv4 action tracker, regularly presented to the ELT (and in summary the Board) which highlights a number of risks that could have a serious impact on future performance; these may not yet be fully reflected in the strategic risk register.

Risk Management

The Head of Strategic Risk and Resilience Planning continues to progress a programme of meetings with each risk owner to ensure all strategic risks are updated to reflect the strategic impact of Covid, although as noted above, we were unable to confirm that all risks identified in the RMPv4 action tracker had been incorporated, and the waiting times risk has yet to be updated. Following discussion at the 21 November 2021 A&RC, all Standing Committees were asked to review the definitions of risks aligned to them, to ensure they accurately represent the current situation and risks which may be faced as a result of Covid. The Committee Assurance Principles questions for scrutiny of risk assurance reports were also circulated at the same time.

The Strategic Risk Management Group met in April, June and October 2021 under the Chairmanship of the Chief Executive. The August 2021 meeting was cancelled due to quoracy issues as a direct result of competing delivery pressures. The Mid Year Risk Management report presented to the November 2021 A&RC confirmed that this did not have any adverse impact with business either being conducted by email or carried forward to the next meeting. The December 2021 was also cancelled and the SRMG is scheduled to meet in February 2022. We recommend that the SRMG reviews its work plan to ensure it will be able to provide appropriate assurance at year end.

Following a September 2021 Strategic Risk BDE, a draft risk appetite statement was circulated to SRMG members on 15 December 2021. If accepted, 11 strategic risks would be above the appetite, 7 within it and 5 below.

It was proposed that where the current risk score exceeds the expressed appetite, additional mitigating actions should be identified, and monitoring increased until the current risk score falls to within acceptable boundaries.

We welcome this development and would recommend that risk appetite should be overtly taken into account during budget setting, resource allocation, decision making and Strategic Planning. We would also suggest that target risks should have an associated timescale, to ensure that there is genuine impetus towards achieving the desired risk level. This might also be built into Directors' objectives in future to provide further impetus and focus.

The organisation should also consider setting a risk tolerance, above which further steps would be required, including a robust Deep Dive setting out the immediate actions being taken and providing enhanced scrutiny and analysis.

Action Point Reference 1 – Risk Management & Performance Reporting

Finding:

Our review of Board and Committee papers highlighted that whilst Board and Committee members are keen to discuss risk, many papers lack adequate, or sometimes any, detail on the associated risks. Where narrative is provided it often does not overtly link to the strategic risk or operational risks nor provide assurance on narrative, scores or the adequacy and effectiveness of key controls and actions.

There is further scope to improve the process by overt scrutiny of the accuracy of scoring of risks and the adequacy and effectiveness of key controls and actions which should be mitigating and reducing the risk.

Performance reports do not overtly link to corporate objectives or provide overt conclusions on the assurance provided on specific risks and whether controls are operating as intended.

Audit Recommendation:

The risk section of Board and Committee papers should be given higher priority than at present and should contain basic information to facilitate a focused discussion on the risk implications, be overtly linked to any operational or strategic risks and contain enough information for members to be able to form a conclusion on whether the score, narrative and other elements of the related risk are adequately described.

The reporting framework at governance level should triangulate resources, performance and risk within the overall governance framework. Best practice would be for monitoring and performance reports to be overtly related to specific risks and to contain an overt conclusion on whether controls are operating as intended, to mitigate the risk effectively. The Standing Committee Governance and Assurance Guidance would be useful in ensuring this triangulation.

This review of performance reporting should consider the increasing significant impact of the Omicron variant and the impact on the current risks and controls.

Assessment of Risk:

Moderate		Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**

Management Response/Action:

The Head of Strategic Risk and Resilience Planning will work with the Board Secretary and Head of Committee Assurance to strengthen the risk sections in Board and Committee Papers and Chairs Assurance Report providing more guidance and headings which must be populated as part of the submission process.

In addition, sessions are to be planned with Committee Chairs, Lead Officers and Committee Support Officers to discuss this, implications of implementation of risk appetite and links with assurance questions. These will be jointly delivered by Head of Strategic Risk and Resilience Planning and Board Secretary. These sessions will consider the need to triangulate resources,

performance and risk and the impact of Covid 19.	
Action by:	**Date of expected completion:**
Board Secretary, Head of Committee Administration, Head of Strategic Risk and Resilience Planning.	**31 August 2022**

Action Point Reference 2 – Policies

Finding:

Policies are currently presented in their entirety to Standing Committees for formal approval, although the membership will not necessarily have the expertise required to assess them and this is not the core business of the Committee. It is hard to discern the added value this brings.

Standing Committees are not however always informed of whether all policies are up to date or the risks associated with any delay.

Audit Recommendation:

The Policy Review and Development Group is currently undertaking a substantial review of the Policy Development, Review and Control Policy.

This review should consider introduction of a system whereby Standing Committees are informed when policies have been updated and provided with assurances that the approval process is robust, rather than approving full polices. Standing Committees should also understand the risks if polices have not been updated and approved.

As part of this review, consideration should be given to whether a non Clinical Policy Governance Group would add value.

Assessment of Risk:

Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**

Management Response/Action:

Agreed. The Policy Review and Development Group have reviewed the policy areas which will now be:

- **Clinical**
- **Workforce**
- **Medicines**
- **Governance (including finance)**
- **Information Governance**
- **Facilities**

The group also requested that there should be a group identified for each policy area to provide assurance regarding the governance of policies within that area. Therefore the following groups will have a responsibility for policy governance:

- **Clinical Policy – Clinical Policy Group**
- **Workforce Policies – Workforce and Governance Forum**
- **Medicines Policies – Medicines Policy Group**
- **Governance (including finance) Policies – Governance Review Group**
- **Information Governance Policies– Information Governance and Cyber Assurance Group**
- **Facilities Policies – Health and Safety Management Committee or Workforce and Governance Forum**

These policy groups will prepare a report for the Standing Committees at least twice a year to provide assurance on the status of the policies and assurance regarding policies that have been approved.	
Action by:	**Date of expected completion:**
Board Secretary	**30 June 2022**

Action Point Reference 3 – Integration

Finding:

Tayside NHS Board has not been updated on progress with MSG actions since December 2019. A SLWG is currently revising Integration Schemes with the aim of having all three schemes signed off in March 2022, although progress has been slow. An update on review of Integration Schemes was provided to the Board Development Event in November 2021.

The SLWG has also identified further areas for development in relation to partner body Standing Financial Instruction, the Getting it Right For Everyone (GIRFE) framework and IJB Standing Orders.

Audit Recommendation:

The Board or a Standing Committee should be provided with an update report on progress with Integration, including the Integration Schemes, MSG and other related actions. A SMART action plan should be approved to monitor this work.

Assessment of Risk:

Moderate  Weaknesses in design or implementation of controls which contribute to risk mitigation.

Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.

Management Response/Action:

The Project Group established by the Tayside Executive Partners (TEPs) continues to meet and reports through a project manager to the TEPs.

The Project Manager has advised the Project Group that the changes to the three revised Integration Schemes have taken account of the actions and recommendations contained within the MSG report.

Once the three revised Integration Schemes have been finalised by the Project Group and approved by the TEPs they will then be presented to NHS Tayside's Executive Leadership Team and Tayside NHS Board for approval to go to public consultation.

Tayside NHS Board will be provided with an update on progress with the review of the Integration Schemes as part of the Action Points Update being taken to the Board meeting on 24 February 2022.

Action by:	Date of expected completion:
Board Secretary and Director of Finance	**31 August 2022**

CLINICAL GOVERNANCE

Strategic Risks

- 26: Waiting Times and RTT Targets
- 16: Clinical Governance
- 934: Mental Health and Learning Disabilities
- 14: Infection Prevention and Control
- 637: Child and Adolescent Mental Health Services (CAMHS)
- 736: Public Protection 798: Corporate Parenting 880: Care Home Oversight
- 353: Sustainable Primary Care Services 1069: Covid-19 Vaccination Programme
- Screening Programmes

Clinical Governance Framework

Progress to revise the Clinical & Care Governance Strategy by the due date of December 2021 was delayed due to Covid-19. This has now been further postponed because of ongoing developments, for example the revision of Integration Schemes which means that the Getting it Right for Everyone (GIRFE) framework will need to be updated. In addition, the agreed development event for the CGC has not yet been scheduled.

The Care Governance Committee (CGC) has been kept informed of these changes, most recently in December 2021. Work will be managed by the Patient Safety, Clinical Governance and Risk Management Team, with a revised target date for completion of September 2022.

The quality of assurance reports provided to the CGC continues to be enhanced and the three Health and Social Care Partnerships, Acute, and Mental Health and Learning Disability Services use improved standardised templates to provide assurance to the CGC. CGC members have made a significant contribution to these improvements.

Internal audit have provided advice on application of committee assurance principles for clinical governance reports and Committee Lead Officers, in conjunction with Clinical Governance colleagues, now provide authors of assurance reports with feedback prior to the Standing Committee agenda planning process, thereby ensuring that reports are robust and contain an appropriate level of information to provide sufficient assurance.

The Operational Unit Clinical Governance Committee has been established to provide assurance on the quality of care at an Acute Services Operational level. Each division will report using an agreed template to enable more focused discussion on clinical governance, including learning and improvement. The Quality and Performance Review process therefore has a focus on performance.

Current reporting to CGC is based on the Vincent framework, which has a focus on measuring and monitoring safety. While the CGC receives a high volume of reporting on safe and person centred care, reporting on effectiveness of care is considerably less prominent.

The Mental Health and Learning Disability In Patient Service Care & Professional Governance Group has revised its meeting structure, membership and terms of reference to further strengthen governance arrangements and the first revised meeting was on 11 November 2021.

Care Governance Committee (CGC)

The CGC approved its Terms of Reference, committee assurance plan and workplan in April 2021. The newly established Clinical Policy Governance group now scrutinises and recommends approval of clinical, nursing and midwifery policies. Responsibility for monitoring Medical and Nursing & Midwifery revalidation has been removed from the CGC remit.

Covid19

During 2021/22 the CGC has received detailed information on Care Homes via the relevant risk assurance report, but there is limited reporting on the impact of Covid-19 on service delivery and on maintenance of clinical governance arrangements.

In response to recommendation 3 in the Annual Internal Audit report 2020/21, management agreed to update the strategic risk on Waiting Times, to be reported to the CGC rather than to the P&RC. While the transfer of the risk has been agreed by the SRMG, the risk has yet to be reviewed and updated.

The CGC did note the impact of Covid19 on activity during discussion of an Acute Services Division Clinical and Care Governance paper at the October 2021 CGC. The paper provided some narrative around the impact of Covid on planned care but did not quantify the impact on patients or describe the mitigations put in place to minimise the risk of serious harm due to deferred treatment. There are also a number of risks associated with the Adult Pathway Bed Capacity and Escalation Plan which have not been escalated to the CGC.

Risk Management

The CGC continued to receive delegated strategic risk assurance reports to at least every second meeting, with detailed and mature risk discussions taking place.

On 5 August 2021 the CGC agreed to reduce the current risk rating of the Clinical Governance strategic risk from 12 to 9 (the target risk score), on the basis of the assurance provided and therefore, in accordance with the RMS, the risk was subsequently archived.

The former clinical governance strategic risk fulfilled a unique function as an anchor for the assurances received by the CGC, as well as acting as the vehicle to help the committee conclude on adequacy and effectiveness of arrangements, and monitor implementation of the Clinical Governance Strategy. The CGC must now determine how it will be assured in future on the adequacy and effectiveness of clinical governance arrangements so that the archiving of this risk does not lead to a diminution in the Committee's ability to deliver its prime assurance.

Strategic risk 353 – Sustainable Primary Care Services is recorded on the NHS Tayside strategic risk register (and those of Angus IJB) with a current risk exposure of 25 and a planned risk exposure of 9. A proposal to transfer the alignment of the risk from Angus IJB to the NHS Tayside Care Governance Committee was discussed at the October 2021 Strategic Risk Management Group, but not approved so that currently, no NHS Tayside Standing Committee has oversight of this 'Very High' risk.

Internal audit T15/22 – Sustainability of Primary Care Services will review this area and provide recommendations for risk, control and assurance.

External Review

While external inspections have mostly been on hold during the pandemic, internal controls in this area still require to be strengthened and our previous 2019/20 ICE recommendation to develop a Standard Operating Procedure for external inspection visits is not fully completed. The procedure was drafted, agreed by ELT and presented to the CGC in February 2020 but taken no further; with the completion date was extended to March 2022, as reported to the August 2021 CGC.

The new Safety Oversight Group will focus on emerging key issues and risks in relation to Patient Safety, Clinical Governance, Complaints and Feedback, as well as evidence of learning and actions from Significant Adverse Event Reviews (SAER). The work of the group has a clear remit to triangulate information from a variety of sources. The group has no reporting lines but it is intended that it can, if it wishes, escalate matters to the CGC. It is not entirely clear how escalation will work in practice or how any assurance can be derived from the work of this group.

The organisation has acknowledged that whilst there is assurance that Scottish Public Services Ombudsman recommendations have been completed, wider organisational learning from these reports could be improved.

Learning from external reviews will feature in the Patient Safety, Clinical Governance & Risk management team's workplan being developed now for 2022/23. An annual report from the team will also then come to the CGC.

Significant Adverse Events (SAEs)

The Adverse Events Policy is currently being updated. Changes have been made to the SAE review process and services now undertake the commissioning role for SAE reviews, including local weekly meetings. An Adverse Event Management Leadership Group provides internal scrutiny, leadership and improvement to adverse event management processes.

The CGC receives data on the number, impact, category and review timescale for adverse events. KPIs for the implementation of actions arising from SAE reviews will be reported to the newly established Safety Oversight Group. Management are considering how to provide meaningful information on whether the findings from these reports raise concerns over the quality of assurances received i.e. should internal systems have prevented the occurrence or at least highlighted the risk of it happening.

Duty of Candour

The 2020/21 Duty of Candour Annual Report was approved for publication by the CGC in August 2021.

Mental Health

The Tayside Mental Health & Wellbeing Strategy was launched by the Chief Executive at the February 2021 Board. The October 2021 Board was informed that the Chief Executive was in active, ongoing discussion with Chief Executives of the Local Authorities, and the Tayside Divisional Commander at Police Scotland to take forward the next steps to deliver a prioritised workplan for the Tayside Mental Health and Wellbeing Strategy. The whole system mental health leadership group continued to meet with Scottish Government on a monthly basis around next steps for mental health service improvement in Tayside with a focus on turning the ambition set out in Living Life Well into a reality.

Year One Priorities have been approved by both the Living Well Operational Steering Group and Programme Board and a planning session to deliver the Implementation Plan for the Year One Priorities took place in November 2021.

Each Board meeting receives a Mental Health update with the Board being informed that '*Within the year 1 agreed priorities a number of projects, workstreams and subgroups are now well-established and actively progressing with agreed deliverables*.'

The Mental Health and Learning Disability Services strategic risk (934) was first reported to the CGC in October 2021. It is managed through collective whole system ownership and is now underpinned by eight system wide service risks. The risk and associated assurance report were reviewed in detail as part of T12/21 – Assurance Mapping, during which Internal Audit provided advice on risk management and assurance principles to the staff involved. Internal audit will continue to review this risk and review assurances as part of the 2021/22 Internal Audit Plan, noting that drug deaths do not currently feature in the Mental Health or any other Strategic risk.

From the above it can be seen that there is a potential dilution of assurance as the Mental Health Risk is reviewed by the CGC but updates on the Mental Health strategy, which is key to the associated risk, are presented to the Board. T11/22 Assurance Mapping will consider this issue further.

The Independent Inquiry into Mental Health Services in Tayside Trust & Respect (the Strang report) progress report was published in July 2021 and presented to the Board in August 2021. The Board meeting on 28 October 2021 was informed that of the 49 recommendations:

- 36 are complete with sufficient evidence
- 2 are complete with partial evidence
- 11 are work in progress but significant progress has been made

Since August 2021, an Operational Medical Director, two new Mental Health and Learning Disability Services Managers and the Lead Nurse for Mental Health have taken up post, strengthening the leadership and management of the service. The first meeting of the Independent Oversight and Assurance Group on Tayside Mental Health Services was held on 16 November 2021. The Group will meet monthly to provide challenge and support to the Tayside Executive Partners and to monitor implementation of the recommendations.

Public Health

The remit, assurance plan and workplan for the Public Health Committee continues to evolve, with acknowledgment that it does not yet capture the full breadth of relevant public health activity. In August 2021, the PHC held a Public Health Strategy Development event covering the purpose of the Strategy, priority areas, stakeholder engagement and how to measure impact. The intention is that a draft Public Health Strategy will be circulated for comments by the end of the calendar year /start of 2022, with the aim of publishing the final Strategy by the end of the 2021/22 financial year.

While Public Health performance reporting has been delayed due to the increased incidence of Covid-19, the scope has widened and it is intended that reporting will also take into account equality of access metrics, given previous discussions by the PHC on the impact of deprivation. The three HSCPs also currently provide verbal updates.

The work of this Committee will be particularly important in informing the Public Health aspects of the new Strategy for NHS Tayside and ensuring the implementation of the updated Fairer Scotland Duty guidance issued in October 2021. The Board Secretary has met with the Chair and Vice Chair of the Public Health Committee who have responsibility for this area on how the organisation can demonstrate that decisions are having a positive impact on social inequalities.

Improvement Activities

Further improvement activities in year included:

- Development of a Person Centred Network;
- Development of a Complaints Handling Improvement Programme;
- Progress of the Public Protection Framework for NHS Tayside since approval in January 2021;
- Feedback from the Sharing Intelligence for Health & Care Group is now shared with the CGC.

Action Point Reference 4 – Waiting Times risk

Finding:

The Annual Internal Audit Report 2020/21 recommended that the Waiting Times risk required fundamental change to reflect the potential for patients to suffer serious harm if services are not prioritised effectively and waiting lists not addressed in the right order. Re-allocation to the CGC was also recommended, as the most important risk and controls directly relate to patient welfare, rather than performance targets. This was agreed by the SRMG on 21 October 2021.

Management agreed that, post-Covid19, the risk would be updated following an impact assessment of the pandemic which would in turn inform future treatment profiles and inform service prioritisation. Prioritisation of services has been a major risk for over a year, and whilst we have been informed that controls are in place, it is of concern that the CGC has not been made aware of the scale of the risk, the controls in place to mitigate it and how the organisation knows that these are operating effectively.

The Adult Pathway Bed Capacity and Escalation Plan, which has the potential to lead to further delays in elective treatment, was agreed by Gold Command in September 2021, noting the risk to delivery and reduction in elective activity, but this has not been escalated to governance level as a potential risk.

The 2020/21 ICE reported that a post Covid19 CGC evaluation and review session would be held to ensure learning around governance and assurance during this period but this has not yet taken place.

Audit Recommendation:

The risk of deferred treatment, which undoubtedly has an extremely high inherent risk, should be quantified and presented to the CGC together with the associated key controls and assurance on their adequacy and effectiveness, in order that the CGC will be able to conclude on key clinical risks by year-end. The Adult Pathway Bed Capacity and Escalation Plan, which has the potential to lead to further delays in elective treatment, should also be taken into consideration in formulating this risk.

The planned post Covid19 CGC evaluation and review session should be rescheduled and should consider the factors within this recommendation.

Assessment of Risk:

Significant		Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores. **Requires action to avoid exposure to significant risks to achieving the objectives for area under review.**

Management Response/Action:

The Waiting Times and RTT Targets strategic risk was realigned to the Care Governance Committee with effect from February 2022. It is however recognised that this risk requires to be re-framed to accurately capture the material issues arising from the long term impacts of Covid. While arrangements have been in place to complete this, these have required to be deferred as a result of the real time response to covid. A revised date will be agreed for this to be taken

forward by the Chief Officer Acute Services in conjunction with the Head of Strategic Risk and Resilience Planning.	
Action by:	**Date of expected completion:**
Chief Officer, Acute Services and Head of Strategic Risk and Resilience Planning	31 March 2022

Action Point Reference 5 – Clinical Governance Strategy

Finding:

The revision of the Clinical & Care Governance Strategy was delayed due to Covid-19 and the revised target date for completion is September 2022.

We were informed that the previously agreed CGC development event on strategy is to be scheduled to co-ordinate with the publication of the next Blueprint for Good Governance. However, this document, whilst not yet formally issued, is widely available and contains no information which would materially impact on the formation of a clinical governance strategy.

Audit Recommendation:

The planned development event should be scheduled as soon as practicable with a clear agenda focusing on developing a project plan to progress the refresh of the Clinical Governance Strategy.

Assessment of Risk:

Moderate

Weaknesses in design or implementation of controls which contribute to risk mitigation.

Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.

Management Response/Action:

At the Care Governance Committee on the 2nd December 2021 it was acknowledged that the work on the revision of the Clinical Governance Strategy was due by the end of 2021. It was delayed due to the competing priorities of Covid19. There was also a review of Integration schemes taking place between the 3 H&SCPs and NHST, the outputs will support the reporting arrangement of clinical governance pan Tayside

The Board Nurse and Medical Director have commissioned a review which is underway into the care governance arrangements and support functions that are required to allow clear reporting structure from operational line to Board for care and clinical governance. The review will identify the support functions that are required to deliver robust clinical governance with an overarching strategy document.

Action by:	Date of expected completion:
Tracey Passway, Interim Associate Director of Patient Safety, Clinical Governance and Risk Management and Sharon Hilton-Christie, Associate Medical Director of Patient Safety, Clinical Governance and Risk Management	**1 October 2022**

Action Point Reference 6 – Assurances to CGC

Finding:

Our review of the assurances provided to the CGC identified the following areas for improvement:

- The clinical governance strategic risk provided a vehicle for providing holistic assurance on the adequacy and effectiveness of clinical governance implementation of the Clinical Governance Strategy. Now that the risk has been archived, the committee will need another mechanism to provide the necessary assurance.
- Reporting is based on the Vincent framework which has a focus on measuring and monitoring safety. While the CGC receives a high volume of reporting on safe and person centred care, there is considerably less focus on providing assurances on effectiveness, including Realistic Medicine.
- The newly established Safety Oversight Group has a key role in triangulation of information from a variety of sources. It is not accountable to any other committee or group and it is not clear how assurance and escalation to the CGC level will operate, if at all.
- The CGC does not receive Key Performance Indicator (KPI) monitoring information on implementing of actions arising from Adverse Event reviews.

Audit Recommendation:

We recommend a review of the CGC Work Plan to ensure all required assurances are provided. This review should consider:

- The mechanism to continue assurances previously delivered through the Clinical Governance strategic risk assurance reports.
- How the CGC can be provided with assurances on effectiveness of clinical care, including Realistic Medicine.
- The mechanism to ensure the Safety Oversight Group provides appropriate assurance and escalates issues to the CGC when required should be clarified.
- How adverse events and other reviews can be used to provide ongoing evidence of whether assurance systems are operating effectively.

Assessment of Risk:

Moderate  Weaknesses in design or implementation of controls which contribute to risk mitigation.

Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.

Management Response/Action:

- **At Care Governance Committee on the 2 December 2021 it was agreed to archive Risk 16, and that to provide continued assurance a suite of service level risks for the Patient Safety, Clinical Governance and Risk Management Team are developed and monitored and exception reported to Care Governance Committee if necessary i.e. if controls deteriorate. It was also agreed at this meeting that the Committee will receive additional assurance in the form of an annual report produced by the Patient Safety, Clinical Governance and Risk Management Team. This report will outline progress with the service level risks and provide assurance on**

matters such as Duty of Candour, Significant Adverse Event Reviews and the Clinical Governance Strategy. The first report will be received by the CGC on 6 October 2022.

- It is agreed there will be a development event for Non Executive Directors and Executive Directors. The development event for Care Governance will include a discussion on how effectiveness of care can and will be assured and any new items that need to be included in the work plan e.g reporting on Realistic Medicine work stream.
- The purpose of the Safety Oversight Group (SOG) meeting is to give the Medical and Nurse Director oversight of emerging key issues/risks regards Patient Safety, Clinical Governance, Complaints and Feedback and evidence of learning and actions from Significant Adverse Event Reviews (SAERs), to enable them to discharge their accountabilities. This allows the Nurse & Medical Director to instruct actions or improvements from SAERs/themes/complaints to the relevant operating unit governance structure up to care governance committee.
- Assurances on effectiveness of adverse events management comes through reporting to CGC directly by Acute Services, Mental Health and Learning Disability Service and the HSCP's. Reports provide assurance on management on adverse events and are starting to contain more information on learning and improvement from adverse events and complaints. Further work is being undertaken to increase the use of the actions module on Datix thereby providing assurance that actions are complete.

Action by:	Date of expected completion:
Tracey Passway, Interim Associate Director of Patient Safety, Clinical Governance and Risk Management	31 March 2022 for development of service level risks
Sharon Hilton- Christie, Associate Medical Director of Patient Safety, Clinical Governance and Risk Management	Annual report 6 October 2022 for report to CGC
Margaret Dunning, Board Secretary	TBC

STAFF GOVERNANCE

Strategic Risks

- 734: Health and Safety
- 844: Nursing Workforce
- 845: Midwifery Workforce
- 863: Medical Workforce
- 58: Workforce Optimisation

Staff Governance Committee

The Staff Governance Committee (SGC) approved their Terms of Reference and the 2021/22 Assurance and Workplan at the June 2021 meeting. The CGC remit no longer includes assurance on professional revalidation and therefore this assurance should now be provided through the SGC, and the SGC remit and work plan updated accordingly.

The December 2021 SGC meeting has been cancelled due to the ongoing pandemic with the next meeting due in February 2022.

Staff Governance Standard

Following approval by the Area Partnership Forum (APF) on 22 September 2021, the October 2021 SGC considered NHS Tayside's response to the National Annual Monitoring Return which also showed NHS Tayside's response to Scottish Government questions.

Guidance is still awaited from the Scottish Government on future staff governance standard monitoring arrangements and there is no requirement to prepare a Staff Governance Action Plan (SGAP) for 2021/22.

Assurances on compliance with the Staff Governance Standards are provided through a variety of reports, rather than by specific reports on each strand of Staff Governance which means that assurances within the regular monitoring reports will need to be reviewed to ensure they provide sufficient coverage across all aspects of the Staff Governance Standard.

Staff experience

The SGC was informed that the recent iMatter survey will be reported to the February SGC.

Rollout of this, the Collective Leadership and Cultural Strategic Framework 2018-2023 and the new Talent Framework had been delayed due to Covid-19, and refreshed presentations came to the June 2021 SGC. The aim is for NHS Tayside to provide a better workplace with positive staff experiences using a new, flexible plan to build a better culture and thus further build its reputation as an employer.

Workforce Planning and Risk Assurance

The interim Workforce Plan was endorsed by the SGC in June 2021 following approval by the APF. It is not clear why the APF appears to have primary responsibility for the workforce plan given that the associated risk lies under the auspices of the SGC, which is the Committee formally charged with monitoring and evaluating progress through the approval of local human resource strategies and implementation plans.

The workforce optimisation risk and associated controls were updated in 2021. The SGC had placed greater emphasis on workforce planning and was receiving regular received enhanced assurance reports on the Workforce Optimisation risk, which also show progress towards the 3 year Workforce Plan. However, the SGC recently decided to reduce the frequency of reporting and there will be a 6

month gap between the last Workforce Optimisation risk assurance report in August 2021 and the next which is due to February 2022.

Workforce Plans are currently due in March 2022, but the expectation is that SG guidance will defer this to July 2022. This has been reported to the APF but not the SGC.

Workforce Planning templates are now complete for all but one service area and key themes have been extracted and incorporated into a progress report to the APF on development of the workforce plan.

Scottish Government have not yet provided clear guidance on the required format of the Workforce Plan and it is not yet clear how implementation of the next iteration will be monitored. We would expect to see monitoring of the workforce plan objectives through a SMART action plan and appropriate KPIs.

As with the Workforce optimisation risk, regular risk assurance reports against the other 4 strategic risks delegated to the committee will now come on a staggered basis to every second meeting, with the intention that this will allow more attention to be focused on each risk. Given that the October 2021 SGC did not receive any risk assurance reports and the December SGC meeting was cancelled, this leaves a considerable gap.

Minutes evidence detailed and mature risk discussions taking place at SGC meetings but the three professional workforce risk assurance reports (medical, nursing and midwifery) continue to provide only limited assurance and discussions did not focus on how these risks would be improved. Again, detailed information on the strategic actions to address them is reported to the APF, rather than the SGC.

As recommended previously, the SGC must have oversight of the development of the workforce strategy and plan, in order to be able to assess and direct the organisation's strategic response to these major risks.

Staff Governance Assurances

The SGC receives Quarterly Staff Governance reports. We welcome the work undertaken to redesign the report format, including seeking SGC members views on presentation and content amongst other aspects. Members requested more benchmarking data and more narrative analysis of the data, in effect a greater emphasis on the quality and analysis of data presented as opposed to the quantity of data. A draft revised format with quarter 2 data was presented in October 2021, and members were again asked to comment.

We do however note that the October 2021 quarterly Staff Governance cover paper states that 'There are no risks arising from this paper', which is clearly incorrect as the paper relates to controls over areas of considerable and increasing risk , which are not currently well assured. Risk can be used as a prism through which raw data is turned into information and much greater focus on what the data tells us about the strategic risks and their mitigation would help answer the request from members for more meaningful analysis.

Remuneration Committee

The Remuneration Committee agreed its remit for 2021/22 in April 2021 and the Committee considered and approved its draft Self-Assessment for 2020/21 in October 2021, which we validated as part of our work for this report.

Executive objectives were not approved before the start of the year in both 2020/21 and 2021/22. This was highlighted as an area of non-compliance by the Remuneration Committee self assessment. This was discussed at the April 2021 Remuneration Committee and it was agreed that work would be undertaken on an adaptive objective setting process to be progressed during 2021/22. However, no further progress has been made in this area.

Whilst we accept that some flexibility may be required, it is important that the Remuneration Committee be informed and approve any revised arrangements as soon as possible.

The 2020/21 ICE recommended that the Remuneration Committee consider succession planning for key strategic posts to manage the risks associated with successful recruitment. A verbal update on the Talent Management Framework and Succession Matrix was provided to the October 2021 Remuneration Committee, highlighting the criticality of developing leaders to the required level of competency and capacity. A proposal to test and develop succession planning within two directorates will be presented to the next Remuneration Committee.

Internal audit T22/21 - Senior Leadership Team Recruitment and Selection, issued 17 November 2021, provided a Reasonable Assurance audit opinion on recruitment processes for Executive level posts and identified areas for improvement in record keeping, training and compliance with the records management policies and guidance.

Health & Safety

The Health and Safety Strategy 2020-2023 & Action Plan is regularly monitored by the SGC. The impact on the health and safety risk will become fully established as H&S activities and projects are implemented and are embedded within the organisational culture. At the request of the Director of Workforce a review of H&S governance has been included in the 2021/22 internal audit plan.

Covid19

The regular Covid19 update papers to the Board include a Workforce Support section, covering lateral flow testing, wellbeing and Covid19 absence.

The Annual Internal Audit report 2021/22 recommended that the SGC receive reports on measures introduced to mitigate risks to staff posed by Covid-19 e.g. physical distancing, risk assessments, PPE etc. with a particular focus on health and safety and wellbeing. However, this has not been completed.

Departmental remobilisation plans were discussed at Local Partnership Fora, and reported to the Area Partnership Forum, but not to the SGC.

Appraisals

The rate of Turas appraisals reported to the August 2021 SGC was 50% (18% completed and 32% in progress), against a target of 95%. Each directorate is now required to complete a recovery plan template with monthly targets, to be reported to SGC in future.

Consultant Appraisal and Medical Revalidation data was last reported to the SGC in April 2021, noting the impact of Covid-19 and that it was anticipated that appraisal would return to its previous levels in 2022. A further update is due for the next SGC meeting. At the same meeting it was reported that GP appraisals for 2020/21 were on track, following suspension of appraisals between March and September 2020, in line with SG guidance.

Statutory and mandatory training

The impact of Covid on training and development was reported to the June 2021 SGC, as part of the NHS Tayside Collective Leadership and Culture Strategic Framework 2018-2023. 'Appropriately trained' is now covered by the Talent Management and Development Strategy. Completion of statutory/ mandatory training remains low and as at August 2021, compliance scores for the 7 modules ranged from 65-80%. Full reporting functionality is being rolled out to enable transparent Statutory and Mandatory training reporting via LearnPro. The SGC has been kept informed of the weaknesses and has initiated action to address these.

Whistleblowing

The 2020/21 Whistleblowing Annual Report was presented to the April 2021 SGC. The Whistleblowing Group considers that satisfactory action was progressed to support successful introduction of the new National Whistleblowing Standards from 1 April 2021, with an action plan in place to support the implementation. Each meeting of the SGC in 2021/22 has received a Whistleblowing Update and the SGC's workplan includes this as a standing agenda item.

Sickness absence

The most recent report to the October 2021 SGC reported the sickness absence rate as 5.62% (equal to the Scottish average). Covid absence is reported under the Covid-19 updates to Board and to Gold Command, but not to the SGC. As reported to the 16 December 2021 Board, Covid-19 absence was 1.97% for the week ending 18 November. We would recommend that the SGC is also kept informed of this important information, alongside other staff related Covid data as recommended previously.

Action Point Reference 7 – Staff Governance Standards

Finding:

Assurances on compliance with the Staff Governance Standards are provided through a variety of reports as detailed in the SGC work plan, rather than by specific reports on each strand of Staff Governance. Whilst this may provide sufficient assurance, it would not be easy for SGC members to conclude on the level of assurance received on each strand or whether all areas had been covered.

In essence, members see individual pieces of the jigsaw, but never the whole picture at any point.

Audit Recommendation:

The assurances within the regular monitoring reports should be presented in a way that allows members to be able to understand how they contribute to the totality of assurance on Staff Governance but also allow identification of any gaps.

Assessment of Risk:

Moderate		Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**

Management Response/Action:

Noted. Discussion will take place with Staff Governance Committee members to seek their view on future format, where they had determined existing format.

Action by:	Date of expected completion:
Director of Workforce	**30 June 2022**

Action Point Reference 8 – Executives Objectives

Finding:

Executives' objectives were not agreed before the start of the year for 2021/22. The Remuneration Committee noted that objective setting and performance management in April 2021 needed to be reviewed but no formal action was recorded and no further update provided to the Remuneration Committee.

Audit Recommendation:

As a priority, the processes around objective setting and performance management for 2021/22 should be clarified and agreed, and Executive objectives agreed.

Assessment of Risk:

Significant		Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores. **Requires action to avoid exposure to significant risks to achieving the objectives for area under review.**

Management Response/Action:

Noted. Process for agreement of objectives already subject to Remuneration Committee discussion to ensure compliance with national timetables. However, internal audit are reminded that Scottish Government wrote in 2020 identifying appraisal, including Executive appraisal as "non-essential activity" and reaffirmed this in writing in late 2021. Therefore the normal process of objective setting and mid-year appraisal were overtaken by Covid19 priorities. A timetable for submission to National Management Performance Committee (NMPC) is an agenda item at the Remuneration Committee on the 15 February 2022.

Action by:	Date of expected completion:
Director of Workforce	**30 June 2022**

FINANCIAL GOVERNANCE

Strategic Risks

- 723: Long Term Financial Sustainability
- 1033: Finance Annual Plan 2021/22
- 636: Prioritisation and Management of Capital funding
- 312: NHS Tayside Estate infrastructure condition
- 615: Effective Prescribing

Financial Planning 2021/22

In line with revised national guidance, a one-year financial plan was produced by NHS Tayside instead of the intended medium term 3-year plan.

The Strategic Finance Plan for 2021/22 was approved at the 29 April 2021 NHS Board meeting. Versions of the plan had been previously considered by the P&RC and the Executive Leadership Team. It was based on the continuing response to the pandemic and on delivering recovery and remobilisation priorities within the funding settlement detailed by Scottish Government. The strategic financial plan, which set out key assumptions and risks, was separated into two distinct elements; the core operational financial plan and the ongoing implications of Covid-19 and the cost of remobilisation.

The plan for 2021/22 identified a requirement for efficiency savings of £27m, noting that the Board's ability to deliver the full savings plan due to the impact of Covid-19 and remobilisation was uncertain. The plan assumed that additional costs relating to the pandemic and subsequent remobilisation would be met in full by the Scottish Government.

Financial Reporting

Finance reporting to Board and P&RC has been transparent and includes clear appendices showing the figures along with appropriate narrative. The Director of Finance has consistently and clearly articulated financial challenges, risks and improvement actions. Key points include:

- The level of certainty around identifying and delivering the high risk savings has improved, but is being achieved using non recurring measures.
- The financial impact of Covid-19 in both the short and longer-term, and its impact on both service delivery and financial plans. Financial sustainability is a significant risk in the absence of certainty on short to medium term direction

The December 2021 Finance Report update to the P&RC provided the Committee with an improved "moderate assurance" assessment when compared to other finance reports for 2021/22. This was due to the second tranche of Covid-19 funding being received in October 2021 and a commitment from Scottish Government of further funding following Quarter 3 where necessary and applicable.

Savings

The savings plan of £27m included indicative savings targets across five themes of which £17m were low risk, £2m medium and £8m high risk savings, with £6m still to be identified.

The latest finance report to the 9 December 2021 P&RC, revised the savings target split as £19m low, £2m medium and £6m still to be identified. Although the report states that recurring savings are low, it does not include the actual savings achieved to date or, therefore a split between recurring and non- recurring savings, which were previously introduced in response to Internal Audit recommendations.

The report stated "*the ability to deliver a break-even position this financial year and the bridging of the savings gap will be reliant on a significant level of non-recurring measures. Such measures*

include risk assessing opportunities to manage the rate of spend, use of contingency, and making use of slippage in earmarked funding allocations." Both External and Internal Audit have previously reported issues around identification and achievement of savings and an over reliance on non-recurring sources and our view is that significant recurrent savings will only now be achieved through strategic change and prioritisation.

A Board Development Event is scheduled for the end of January 2022 where the Director of Finance will provide a detailed financial presentation on the financial plan, including achievement of savings.

Risk Management

Financial risks are aligned to the P&RC, with the Revenue Financial Report (RFR) including an assessment against Risk 723: Long Term Financial Sustainability and Risk 1033: Finance Annual Plan 2021/22.

The RFR to the December 2021 P&RC meeting, for the financial period to 31 October 2021, reported Risk 723 current exposure as 20 with a target score of 12 and Risk 1033 as 16 with a target score of 12.

The report highlighted that the risk exposure score for Risk 723 has remained static during 2021/22, due to the continued level of uncertainty with regard to Covid-19 and remobilisation funding in future years, and the one year planning cycle that Boards have been asked to undertake for 2021/22. The assessment of adequacy of the current controls in respect of Strategic Risk 723 has been recorded as being 'incomplete', meaning that 'controls are appropriately designed but these are not consistently applied', although it does not specify which controls are not being applied effectively. (See Audit Recommendation 1).

Strategic Risk 1033 current risk exposure rating has reduced to 16, from 20. The update to the risk rating within the RF to the December 2021 P&RC meeting reflects further clarity around the funding allocations for 2021/22 and the current position against financial plan trajectory. The assessment of adequacy of the current controls in respect of Strategic Risk 1033 has been recorded as being 'adequate', meaning that 'controls are in place/working effectively/consistently applied and adhered to, to mitigate the risk'.

Capital Plan and Property Strategy

Whilst the Scottish Government has deferred the requirement for Property Asset Management Strategy updates and completion of the SAFR pro-formas, property management will be a key component of the Boards overall strategy, both in terms of determining future options and ensuring their effective delivery. As such, P&RC should receive a report on the PAMS, with a clear timetable for delivery of an updated Strategy to support the Board going forward. All related impacts of COVID will need to be considered. This work has clear links to the actions arising from Internal audit Report T24/21 (see below).

The Five Year Capital Plan 2021/22 was approved by the Board in April 2021 based on an assessment of current priorities. The draft Capital Plan also assumes that there will be no additional capital funding allocated from SG to support Covid19 capital expenditure.

Capital Reporting to the December 2021 P&RC meeting provided a moderate level of assurance as planned expenditure continues to be impacted by delays in major capital projects under construction and the availability of staff resource to support further initiatives.

Risk 636: Prioritisation and Management of Capital Funding highlights capacity issues within the Property Team, including the availability of project management and technical staff to support the development and implementation of capital projects.

Internal audit report T24/21 Property Management concluded that NHS Tayside's strategic property management requires fundamental review and made a number of recommendations aimed at

ensuring that property & asset management supports the achievement of strategic objectives. The full report was presented to the Sept 2021 A&RC and an update on progress is to be provided by the Director of Facilities to the January 2022 Audit and Risk Committee.

Other Areas covered by ICE Fieldwork

We also reviewed the following areas, none of which highlighted any issues of note:

- Standing Financial Instructions;
- Standards of Business Conduct;
- Anti-Fraud and Corruption Policy and Response Plan;
- Financial Operating Procedures;
- Control over the Acquisition, Use, Disposal and Safeguarding of Assets.

Environmental Reporting

Strategic Risk 807: Statutory Obligations in Relation to Environmental Management was developed in October 2020 and is assigned to the P&RC. The latest report to the October 2021 P&RC gave only "limited assurance" with controls incomplete.

A mandatory policy for NHS Scotland on the Climate Emergency and Sustainable Development - DL (2021) 38, was issued on 10 November 2021, with immediate effect. The DL will almost have a significant impact on Capital Planning.

A review of the environmental management governance is underway. Significant improvement at pace will be needed for to achieve SG directions and mitigate the risk.

Action Point Reference 9 – Property Asset Management Strategy

Finding:

The PAMs and Capital Programme is a vital part of supporting the future developing Clinical Strategy and delivering its prioritised outcomes. This year the P&RC has not received assurance that the PAMS is being updated and how it will inform and support the Boards overall Strategy.

Audit Recommendation:

The P&RC should be provided with assurance that preparatory work within the PAMS is being carried out to inform and support the developing Strategy and with a clear timetable for delivery of an updated PAMS.

Assessment of Risk:

Moderate  Weaknesses in design or implementation of controls which contribute to risk mitigation.

Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.

Management Response/Action:

The programme for the development of the 2022 Regional Asset Management Plan (RAMP) has been issued, and outlines the actions and timescales required allowing each of the North NHS Boards to submit relevant information in the form of each of their own Property Asset Management Strategies (PAMS) – this includes NHS Tayside. The PAMS is being co-ordinated through the CEL 35 group, reporting into the Asset Management Group (AMG), and is gathering relevant clinical and service development plans to inform the asset strategy by the start of the next financial year (2022/23).

The NHS Tayside PAMS response will include references to the development of both Primary Care Strategic Development Plans and the Ninewells Business Continuity Review work that is being carried out in 2022. The procurement of external advisor support for this work is underway through the Health Facilities Scotland (HFS) Framework Scotland. This will constitute the local NHS Tayside PAMS, which will then be compiled with the other North area Boards into the RAMP, identifying common themes, and areas of mutual activity and support in the North Region. Once completed the RAMP will be submitted for review and approval to the Executive Leadership Team (ELT), the Primary Care Premises & Infrastructure Group (PCPIG), the Asset Management Group (AMG), the Performance & Resource Committee (P&RC), and finally NHS Tayside Board.

Action by:	Date of expected completion:
Property Asset Manager	**30 June 2022**

INFORMATION GOVERNANCE

Strategic Risks

Risk 679: eHealth Technical Infrastructure and Modernisation Program

Risk 680: eHealth Cyber Security Attack

Information Governance (IG) and Digital Arrangements

The P&RC has responsibility for monitoring the development and delivery of the Digital Strategy as well as the Digital Annual Operating Plan and the two eHealth Strategic Risks. The P&RC workplan for 2021/22 includes updates on the development of the Digital Strategy but not approval of the final version or monitoring its implementation. It has been recognised that the Digital Strategy is not fully funded but there is no formal route for the P&RC to monitor and approve prioritisation of schemes within the strategy, either individually or through consideration of an overall prioritisation process.

Internal Audit will review the Digital Governance arrangements and the affordability of the Digital Strategy within internal audit T30/22 – Digital & eHealth. The A&RC is provided with assurance on IG and Cyber Assurance Compliance through a midyear and annual report, and compliance reporting for Network and Information Systems regulations. The minutes of the IG and Cyber Assurance Committee (IGCAC) are also presented to the A&RC. Different elements of Cyber Risk and Assurance are reported to both the P&RC and A&RC, thus splitting assurances and creating duplication.

IG Policies and Procedures

Review dates for some IG and Security policies have passed, including important overarching policies. The review of IG policies should specifically consider the impact of the pandemic and the increase in fraud risk and remote working implications.

The IG Team plan to enhance arrangements through the development of an IG Framework with associated policies, this should reduce the number of IG policies currently in place.

IG Incidents and Reporting

The IGCAC receives reports on data breaches within the IGCAC Assurance report to each meeting but the detail provided only relates to ICO Responses and the number of data breaches.

The A&RC receive high level reports on the number of data breaches as part of the IG midyear and yearend report however these do not provide any background or allow consideration of whether it might require Governance Statement Disclosure. Reporting should be enhanced to include a brief description of the ICO incidents, the number of IG incidents reported to the ICO, whether these were reported within the 72-hour deadline, feedback from the competent authority (No Further Action, Enforcement or Pending) and whether any of these should be considered for disclosure in the Board's Governance Statement. The Head of IG has been informed of this finding.

Internal audit Report T29/22 – Missing Clinical Psychology highlighted that a loss of 87 records containing highly personal data had not been considered for inclusion in the Governance Statement, despite the seriousness of the event and the fact that the first losses were identified in December 2020.

IG Responsibilities

An NHS Tayside Senior Information Risk Owner (SIRO) and Data Protection Officer (DPO) are in place.

Risk Management

Action point 6 within the Internal Audit Annual Report 2020/21 recommended that an IG risk register should be produced with reporting of the register to each meeting of the IGCAC with overt linkage to IG aspects of the two digital strategic risks. The action taken by management is in accordance with the management response, but does not necessarily address the underlying issues as it has merely recorded existing risks on Datix, rather than actively considering the totality of the risk environment and ensuring that there is an operational risk for each component. An overarching IG risk with links to individual components, such as that created for Mental Health, would be considerably more robust.

Following a rationalisation of the strategic risks for IG and eHealth in 2019/20, the P&RC now receives assurance reports every 2 months for both the Technical Infrastructure and Modernisation Programme risk (rated high) and the Cyber Security Attack Strategic Risk, (rated medium).

In the latter part of 2020/21, the score for the Technical Infrastructure and Modernisation Programme risk reduced from 'very high' to 'high', where it has stayed. However, further reduction to the target risk of moderate will require significant additional work.

The Cyber Security Attack Strategic risk score has recently reduced to 'medium' with a major milestone reached in NHS Tayside cyber security defences. The installation and implementation of the Quarantined Virtual Local Area Network (QVLAN) Firewalls at Ninewells, PRI and Stracathro now actively protect the medical devices network from cyber-attack. This is recognised as a significant development, however continued work and investment is required to maintain and enhance protection levels.

A Cyber Incident Response Plan has been produced and an initial tabletop exercise was carried out across Digital to understand the organisations ability to respond to a cyber-attack. A Cyber Alert Response Plan has been produced to supplement the Cyber Incident Response Plan and these are included as key controls within the Cyber Risk.

There was evidence of the impact of the pandemic having been considered in responses to both the Digital strategic risks and of risk scores reducing towards their target.

IG Assurance Reporting – Mid Year Report

The IG Midyear report was presented to the November 2021 A&RC meeting although it did not overtly link to the Cyber Strategic Risk.

This midyear report provides a "snapshot" of all IG activity. However, the section on Data Breaches does not provide any clarity on whether these may be possible Governance Statement Disclosures and the Freedom of Information section does not report on compliance with the national target.

Four members of the IGCAC have not attended any of the three meetings to date in 2021/22.

Network and Information Systems Regulations (NISR)

The Network and Information Security (NIS) audit recommendations work plan presented to the A&RC on 20 May 2021 provided an update on action taken and planned to address the 108 recommendations made in the Competent Authority Audit Report published in November 2020.

Further updates were provided to the September and November 2021 A&RC. The Final Report was issued by the Competent Authority in August 2021. The number of recommendations has now reduced to 89 following the completion of 19.

The most recent NISR update reflected the 55% compliance status as well as showing the number of outstanding actions with in a priority scale (Critical, Urgent, Important, Attention, Guidance).

Digital Strategy

The development of the Digital Strategy and delivery against the Digital Annual Operational Plan continues to be reported to the P&RC. Updates to P&RC reflect that affordability of delivering the current projects is an ongoing issue, as is the delivery and financial costs of the draft Digital Strategy.

With the consultation process now complete, the Digital Strategy is now with the Chief Executive for consideration. We expect the Digital Strategy to be approved by the P&RC and possibly the NHS Board before it is formally launched.

Action Point Reference 10 – Digital Strategy

Finding:

The P&RC workplan for 2021/22 includes updates on the development of the Digital Strategy; but not approval of the final version or monitoring its implementation. It has been recognised that the Digital Strategy is not fully funded but there is no formal route for the P&RC to monitor and approve prioritisation of schemes within the strategy, either individually or through consideration of an overall prioritisation process.

Audit Recommendation:

As the Digital Strategy is progressing towards being finalised, the following governance requirements need to be considered:

- Approval of the Digital Strategy by the P&RC;
- Future monitoring arrangements of the delivery of the Strategy;
- The role of the P&RC in prioritising Digital Funding.

Assessment of Risk:

Moderate  Weaknesses in design or implementation of controls which contribute to risk mitigation.

Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.

Management Response/Action:

Approval of the Digital Strategy by the P&RC:

The Digital Strategy is due to be presented at the next Performance and Resources Committee on 14 April. The Digital Director will present the strategy for formal approval. We will also concurrently seek the formal approval of the Chief Executive.

Future monitoring arrangements of the delivery of the Strategy:

We will present a year-by-year operational delivery plan that will detail each workstream and programme. Regular updates on progress will be presented to the Performance and Resources Committee for formal monitoring of delivery.

The role of the P&RC in prioritising Digital Funding:

This is a matter for the Performance and Resources Committee and Finance, however we will present a robust business case for each proposed programme of work together with ROI details in order to gain P&RC and Finance approval.

Action by:	Date of expected completion:
Director of Digital Technology	**30 June 2022**

Action Point Reference 11 – IG Arrangements

Finding:

IG and Digital assurances are provided to both the A&RC and the P&RC. Different elements of Cyber Risk and Assurance are reported to both the P&RC and A&RC, thus splitting assurances and creating duplication.

Audit Recommendation:

A complete package of risk and assurance reporting to only one Standing Committee for Cyber Security would provide a more comprehensive approach to the management and reporting of cyber risks for NHS Tayside and ensure there is no duplication or gaps in reporting.

Governance arrangements should be reviewed and only one Standing Committee should be responsible for monitoring all IG and Digital risks, assurance reporting and consideration of supporting minutes.

Assessment of Risk:

Merits Attention

There are generally areas of good practice.

Action may be advised to enhance control or improve operational efficiency.

Management Response/Action:

The Board Secretary organised a meeting to discuss this Audit Recommendation with the Lead Officers for the Audit and Risk Committee and the Performance and Resources Committee, Internal Audit, the Head of Information Governance and Cyber Assurance and the Head of Operations, Digital Directorate.

The group discussed the previous reporting arrangements and the current arrangements which include reporting of the two strategic risks to the Performance and Resources Committee, the Cyber Attack Risk and the eHealth Technical Infrastructure and Modernisation Programme Risk, and the compliance and assurance reporting of the Network Information Systems Regulations 2018 to the Audit and Risk Committee.

Following discussion the group agreed that the current reporting arrangements should remain. The reason for the decision is as follows:

The Network and Information Systems regulations that came in to force in 2018 set out the standards with which NHS Tayside as an Operator of Essential services must comply. The standards are broad and cover a number of organisation wide matters, which include: organisational governance and leadership, risk management, supplier management, asset management, information security management, people, service resilience, access control to information systems, media management, environmental security, physical/building security, system management protection, operational security to protect systems and digital services, network security measures to protect information and information held in networks, incident detection to monitor potential cyber attacks, incident management, business continuity.

The compliance or non compliance with these regulations affect the whole organisation and are a critical part of NHS Tayside's systems of internal control. Therefore given the broad coverage of the regulations it is felt appropriate that the reporting against these is to the Audit and Risk

Committee, as the Audit and Risk Committee is responsible to Tayside NHS Board for assurance regarding the systems and processes of internal control. **The reason the decision was taken to move the reporting of the two risks (the Cyber Attack Risk and the eHealth Technical Infrastructure and Modernisation Programme Risk) from the Audit and Risk Committee to the Performance and Resources Committee was because a large element of the mitigation of these risks would be the allocation of required resources to support the work and developments required in these areas.**	
Action by:	**Action by:**
Board Secretary	**Complete**

Action Point Reference 12 - IG Assurance Reports – Mid Year Report	
Finding:	
The IG Midyear report was presented to the November 2021 A&RC meeting although it did not overtly link to the Cyber Strategic Risk. Four members of the IGCAC have not attended any of the three meetings to date in 2021/22.	
Audit Recommendation:	
The following should be considered as part of the IGCAC mid and year end reporting: • Clear links to the Cyber Strategic risk; • SBAR Risk assessment consideration of known risks. Members of the IGCAC should be reminded of the importance of attending IGCAC meetings or sending deputies.	
Assessment of Risk:	
Merits Attention 	There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**
Management Response/Action:	
Members of the Information Governance and Cyber Assurance Committee will be reminded of the importance of attending the Committee when the papers for the March 2022 meeting are circulated. This will be highlighted at the meeting and recorded in the minutes. This matter will also be drawn to the attention of relevant Directors following the meeting to ensure that the importance of attending this meeting is recognised.	
Action by:	**Date of expected completion:**
Board Secretary	**31 March 2022**

Assessment of Risk

To assist management in assessing each audit finding and recommendation, we have assessed the risk of each of the weaknesses identified and categorised each finding according to the following criteria:

Risk Assessment		Definition	Total
Fundamental		Non Compliance with key controls or evidence of material loss or error. **Action is imperative to ensure that the objectives for the area under review are met.**	None
Significant		Weaknesses in design or implementation of key controls i.e. those which individually reduce the risk scores. **Requires action to avoid exposure to significant risks to achieving the objectives for area under review.**	2
Moderate		Weaknesses in design or implementation of controls which contribute to risk mitigation. **Requires action to avoid exposure to moderate risks to achieving the objectives for area under review.**	7
Merits attention		There are generally areas of good practice. **Action may be advised to enhance control or improve operational efficiency.**	3